United States providing for women's suffrage.''

The duties of the Commission, as written in the law, include: (1) To encourage, plan, develop, and execute programs, projects, and activities to commemorate the centennial of the passage and ratification of the 19th Amendment; (2) To encourage private organizations and State and local Governments to organize and participate in activities commemorating the centennial of the passage and ratification of the 19th Amendment; (3) To facilitate and coordinate activities throughout the United States relating to the centennial of the passage and ratification of the 19th Amendment; (4) To serve as a clearinghouse for the collection and dissemination of information about events and plans for the centennial of the passage and ratification of the 19th Amendment; and (5) To develop recommendations for Congress and the President for commemorating the centennial of the passage and ratification of the 19th Amendment.

Meeting Agenda for October 3, 2019

- Call to Order, Opening Remarks, Roll Call
- Housekeeping Announcement
- Approval of Meeting Minutes
- Executive Director Update
- Communications Update
- Subcommittee Updates
- Lunch Break *(Presentation)*
- Public Comment
- Wrap Up/Next Steps
- Adjourn

The meetings are open to the public, but pre-registration is required. Any individual who wishes to attend the meeting should register via email at *kmoliver@blm.gov* or telephone 202–208–7301.

Interested persons may choose to make a public comment at the meeting during the designated time for this purpose. Public comments shall be limited by minutes based on the number of participants signed up to comment for the allotted time, and subject to agenda time changes based on the speed of the commission's work through the agenda. Speakers who wish to expand upon their oral statements, or those who had wished to speak but could not be accommodated on the agenda, may submit written statements up to 30 days after the meeting.

Members of the public may also choose to submit written comments by mailing them to Kim Oliver, Designated Federal Officer, 1849 C Street NW, Room 7313, Washington, DC 20240, or via email at *kmoliver@blm.gov.* Please contact Ms. Oliver at the email address above to obtain meeting materials. All written comments received will be provided to the Commission. Detailed minutes of the meeting will be available for public inspection within 90 days of the meeting.

Individuals requiring special accommodations to access the public meeting should contact Ms. Oliver at least five business days prior to each meeting, so that appropriate arrangements can be made.

Public Disclosure of Comments

Before including your address, phone number, email address, or other personally identifiable information (PII) in your comment, you should be aware that your entire comment—including your PII—may be made publicly available at any time.

While you can ask us in your comment to withhold your PII from public review, we cannot guarantee that we will be able to do so.

Dated: September 5, 2019.

Rebecca Kleefisch,

Executive Director, Women's Suffrage Centennial Commission.

[FR Doc. 2019–19987 Filed 9–13–19; 8:45 am]

BILLING CODE 3420–37–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Performance Review Board Members

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Centers for Disease Control and Prevention (CDC) located within the Department of Health and Human Services (HHS) is publishing the names of the Performance Review Board Members who are reviewing performance of Senior Executive Service (SES) members, Title 42 (T42) executives, and Senior Level (SL) employees for Fiscal Year 2019.

FOR FURTHER INFORMATION CONTACT: Sandra De Shields, Team Chief, Executive and Scientific Resources Office, Human Resources Office, Centers for Disease Control and Prevention, 11 Corporate Square Blvd., Mailstop US11–2, Atlanta, Georgia 30341, Telephone (770) 488–0252.

SUPPLEMENTARY INFORMATION: Title 5, U.S.C. Section 4314(c) (4) of the Civil Service Reform Act of 1978, Public Law 95–454, requires that the appointment of Performance Review Board Members be published in the **Federal Register**. The following persons will serve on the CDC Performance Review Board, which will oversee the evaluation of performance appraisals of Senior Executive Service members for the Fiscal Year 2019 review period:

Dean, Hazel, Co-Chair
Shelton, Dana, Co-Chair
Arispe, Irma
Boyle, Coleen
Curlee, Robert C.
Kitt, Margaret
Kosmos, Christine
Peeples, Amy
Pirkle, James
Qualters, Judith
Ruiz, Roberto
Smagh, Kalwant

Sandra Cashman,

Executive Secretary, Centers for Disease Control and Prevention.

[FR Doc. 2019–19957 Filed 9–13–19; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6063–N5]

Medicare Program; Extension of Prior Authorization for Repetitive Scheduled Non-Emergent Ambulance Transports

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces a 1-year extension of the Medicare Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport. The extension of this model is applicable to the following states and the District of Columbia: Delaware, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia.

DATES: This extension begins on December 2, 2019 and ends on December 1, 2020.

FOR FURTHER INFORMATION CONTACT: Angela Gaston, (410) 786–7409.

Questions regarding the Medicare Prior Authorization Model Extension for Repetitive Scheduled Non-Emergent Ambulance Transport should be sent to *AmbulancePA@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Medicare may cover ambulance services, including air ambulance (fixed-wing and rotary-wing) services,

only if the ambulance service is furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

Non-emergent transportation by ambulance is appropriate if either the—(1) beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or (2) beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of non-emergent ambulance transportation; rather, it is one factor that is considered in medical necessity determinations.[1]

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished in 3 or more round trips during a 10-day period, or at least 1 round trip per week for at least 3 weeks.[2] Repetitive ambulance services are often needed by beneficiaries receiving dialysis or cancer treatment.

Medicare may cover repetitive, scheduled non-emergent transportation by ambulance if the—(1) medical necessity requirements described previously are met; and (2) ambulance provider/supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements are met (see 42 CFR 410.40(d)(1) and (2)).[3]

In addition to the medical necessity requirements, the service must meet all other Medicare coverage and payment requirements, including requirements relating to the origin and destination of the transportation, vehicle and staff, and billing and reporting. Additional information about Medicare coverage of ambulance services can be found in 42 CFR 410.40, 410.41, and in the Medicare Benefit Policy Manual (Pub. 100–02), Chapter 10, at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf.*

According to a study published by the Government Accountability Office in October 2012, entitled ''Costs and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased,'' [4] the number of basic life support (BLS) non-emergent transports for Medicare Fee-For-Service beneficiaries increased by 59 percent from 2004 to 2010. A similar finding published by the Department of Health and Human Services' Office of Inspector General (OIG) in a 2006 study, entitled ''Medicare Payments for Ambulance Transports,'' [5] indicated a 20 percent nationwide improper payment rate for non-emergent ambulance transport. Likewise, in June 2013, the Medicare Payment Advisory Commission published a report [6] that included an analysis of non-emergent ambulance transports to dialysis facilities and found that, during the 5-year period between 2007 and 2011, the volume of transports to and from a dialysis facility increased 20 percent, more than twice the rate of all other ambulance transports combined. More recently, in September 2015, the OIG reported [7] that approximately one in five ambulance suppliers had questionable billing, and that suppliers that had questionable billing provided nonemergency basic life support transports more often than other suppliers.

Section 1115A of the Social Security Act (the Act) authorizes the Secretary to test innovative payment and service delivery models expected to reduce program expenditures, while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries.

In the November 14, 2014 **Federal Register** (79 FR 68271), we published a notice entitled ''Medicare Program; Prior Authorization of Repetitive Scheduled Non-emergent Ambulance Transports,'' which announced the implementation of a 3-year Medicare Prior Authorization model under the authority of section 1115A of the Act that established a process for requesting prior authorization for repetitive, scheduled non-emergent ambulance transport rendered by ambulance suppliers garaged in three states (New Jersey, Pennsylvania, and South Carolina). These states were selected as the initial states for the model because of their high utilization and improper payment rates for these services. The model began on December 1, 2014, and was originally scheduled to end in all three states on December 1, 2017.

In the October 23, 2015 **Federal Register** (80 FR 64418), we published a notice titled ''Medicare Program; Expansion of Prior Authorization of Repetitive Scheduled Non-emergent Ambulance Transports,'' which announced the inclusion of six additional states (Delaware, the District of Columbia, Maryland, North Carolina, West Virginia, and Virginia) in the Repetitive Scheduled Non-Emergent Ambulance Transport Prior Authorization model in accordance with section 515(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10). These six states began participation on January 1, 2016, and the model was originally scheduled to end in all nine model states on December 1, 2017.

In the December 12, 2017 **Federal Register** (82 FR 58400), we published a notice titled ''Medicare Program; Extension of Prior Authorization for Repetitive Scheduled Non-Emergent Ambulance Transports,'' which announced a 1-year extension of the prior authorization model in all states through December 1, 2018.

In the December 4, 2018 **Federal Register** (83 FR 62577), we published a notice titled ''Medicare Program; Extension of Prior Authorization for Repetitive Scheduled Non-Emergent Ambulance Transports,'' which announced a 1-year extension of the prior authorization model in all states through December 1, 2019.

II. Provisions of the Notice

This notice announces that the testing of the model under section 1115A of the Act is again being extended in the current model states of Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia for an additional year while we continue to work towards nationwide expansion under section 1834(l)(16) of the Act. The existing testing of the model under section 1115A authority is currently scheduled to end in all states on December 1, 2019; however, this notice extends the model under the authority in section 1115A of the Act through December 1, 2020.

Under this extension of the model under section 1115A authority, we will continue to test whether prior authorization helps reduce expenditures, while maintaining or improving quality of care, using the prior authorization process as described in 83 FR 62577. Section 1115A(d)(1) of

[1] 42 CFR 410.40(d)(1).

[2] Program Memorandum Intermediaries/Carriers, Transmittal AB–03–106.

[3] Per 42 CFR 410.40(d)(2), the physician's order must be dated no earlier than 60 days before the date the service is furnished.

[4] Government Accountability Office ''Cost and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased'' (GAO–13–6) (October 2012).

[5] Office of Inspector General ''Medicare Payment for Ambulance Transport'' (January 2006).

[6] Medicare Payment Advisory Commission, June 2013, pages 167–193.

[7] Office of Inspector General ''Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports'' (September 2015).

the Act authorizes the Secretary to waive such requirements of Titles XI and XVIII, as well as sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5)) of the Act as may be necessary solely for purposes of carrying out section 1115A of the Act with respect to testing models described in section 1115A(b) of the Act. Consistent with this standard, we will continue to waive the same provisions of Title XVIII for the extension of this model as have been waived for purposes of testing the model over the previous five years. Additionally, we have determined that the implementation of this model does not require the waiver of any fraud and abuse law, including sections 1128A, 1128B, and 1877 of the Act. Thus ambulance suppliers affected by this model must comply with all applicable fraud and abuse laws.

We will continue to use this prior authorization process to help ensure that all relevant clinical or medical documentation requirements are met before services are furnished to beneficiaries and before claims are submitted for payment. The prior authorization process further helps to ensure that payment complies with Medicare documentation, coverage, payment, and coding rules.

The use of prior authorization does not create new clinical documentation requirements. Instead, it requires the same information that is already required to support Medicare payment, just earlier in the process. Prior authorization allows ambulance suppliers to address coverage issues prior to furnishing services.

The prior authorization process under the extension of the model under 1115A authority will continue to apply in the nine states listed previously for the following codes for Medicare payment:

- A0426 Ambulance service, advanced life support, non-emergency transport, Level 1 (ALS1).
- A0428 Ambulance service, BLS, non-emergency transport.

While prior authorization is not needed for the mileage code, A0425, a prior authorization decision for an A0426 or A0428 code will automatically include the associated mileage code.

Under the model extension under section 1115A authority, we will continue our outreach and education efforts to ambulance suppliers, as well as beneficiaries, through such methods as updating the operational guide, frequently asked questions (FAQs) on our website, a physician letter explaining the ambulance suppliers' need for the proper documentation, and educational events and materials issued by the Medicare Administrative Contractors (MACs).

We will continue to work to limit any adverse impact on beneficiaries and to educate beneficiaries about the model process. If a prior authorization request is non-affirmed, and the claim is still submitted by the ambulance supplier, the claim will be denied, but beneficiaries will continue to have all applicable administrative appeal rights. We will also continue our initiative to help find alternative resources for beneficiaries who do not meet the requirements of the Medicare repetitive scheduled non-emergent ambulance transport benefit.

Additional information is available on the CMS website at *http://go.cms.gov/PAAmbulance.*

III. Collection of Information Requirements

Section 1115A(d)(3) of the Act states that chapter 35 of title 44, United States Code (the Paperwork Reduction Act of 1995), shall not apply to the testing and evaluation of models or expansion of such models under this section. Consequently, this document need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

IV. Regulatory Impact Statement

This document announces a 1-year extension of the Medicare Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport. Therefore, there are no regulatory impact implications associated with this notice.

Authority: Section 1115A of the Social Security Act.

Dated: August 22, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2019–19886 Filed 9–13–19; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS–R–153]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by October 16, 2019.

ADDRESSES: When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be received by the OMB desk officer via one of the following transmissions: OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–5806 *OR*, Email: *OIRA_submission@omb.eop.gov.*

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' website address at website address at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html.*

1. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov.*

2. Call the Reports Clearance Office at (410) 786–1326.

FOR FURTHER INFORMATION CONTACT: William Parham at (410) 786–4669.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of